		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041608

Facility Name: ASTA CARE CENTER OF ELGIN

Address: 134 N. MCCLEAN BOULEVARD (Number) ELGIN (City) 60123 (Zip Code)

County: KANE

Telephone Number: (847) 742-8822 **Fax #** (847) 742-9013

IDPA ID Number: 36-4069629

Date of Initial License for Current Owners: 03/29/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MICHAEL GILLMAN
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	52	Skilled (SNF)	52	18,980	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	102	TOTALS	102	37,230	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,596	2,596	8
9	SNF/PED					9
10	ICF	25,127	4,123	1,278	30,528	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,127	4,123	3,874	33,124	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.97%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/29/96

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 03/29/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 24 and days of care provided 1,826

Medicare Intermediary ADMINISTAR OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	198,397	19,455	7,373	225,225		225,225		225,225			1
2	Food Purchase		129,610		129,610		129,610	(1,388)	128,222			2
3	Housekeeping	176,702	23,267		199,969		199,969		199,969			3
4	Laundry	52,646	12,297	1,821	66,764		66,764		66,764			4
5	Heat and Other Utilities			85,131	85,131		85,131		85,131			5
6	Maintenance	36,263	23,380	19,108	78,751		78,751	3,091	81,842			6
7	Other (specify):*			17,578	17,578		17,578		17,578			7
8	**TOTAL General Services**	464,008	208,009	131,011	803,028		803,028	1,703	804,731			8
	B. Health Care and Programs											
9	Medical Director			9,250	9,250		9,250		9,250			9
10	Nursing and Medical Records	1,042,235	65,564	41,988	1,149,787	1,200	1,150,987	2,165	1,153,152			10
10a	Therapy	125,480	2,748		128,228		128,228		128,228			10a
11	Activities	70,932	10,250	2,064	83,246		83,246		83,246			11
12	Social Services	30,725		1,992	32,717		32,717		32,717			12
13	Nurse Aide Training											13
14	Program Transportation			160	160		160		160			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,269,372	78,562	55,454	1,403,388	1,200	1,404,588	2,165	1,406,753			16
	C. General Administration											
17	Administrative			167,197	167,197		167,197	(28,025)	139,172			17
18	Directors Fees											18
19	Professional Services			54,080	54,080	(1,200)	52,880	664	53,544			19
20	Dues, Fees, Subscriptions & Promotions			22,226	22,226		22,226	(13,303)	8,923			20
21	Clerical & General Office Expenses	122,244	16,593	32,160	170,997		170,997	16,993	187,990			21
22	Employee Benefits & Payroll Taxes			264,544	264,544		264,544		264,544			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,263	3,263		3,263		3,263			24
25	Other Admin. Staff Transportation			780	780		780	2,741	3,521			25
26	Insurance-Prop.Liab.Malpractice			105,617	105,617		105,617	1,074	106,691			26
27	Other (specify):*			4,241	4,241		4,241	3,881	8,122			27
28	**TOTAL General Administration**	122,244	16,593	654,108	792,945	(1,200)	791,745	(15,975)	775,770			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,855,624	303,164	840,573	2,999,361		2,999,361	(12,107)	2,987,254			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: ASTA CARE CENTER OF ELGIN #0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,800	
	REPAIRS & MAINTENANCE		1,819	
	OUTSIDE SERVICE		754	7,373
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,821	
			0	1,821
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		27,355	
	ELECTRICITY		34,158	
	WATER		23,129	
	CABLE TV - LOBBY		489	
			0	85,131
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,642	
	PAINTING & DECORATING		925	
	BUILDING REPAIRS		1,476	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		5,470	
	ELEVATOR MAINTENANCE & REPAIR		3,551	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,075	
	FIRE SERVICE		4,452	
	COST REBILLED - SALARIES		(2,483)	
			0	
			0	19,108
7	**OTHER**			
	SCAVENGER		17,578	
	SECURITY SERVICE		0	17,578
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,250	9,250

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	22,076	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	3,324	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,472	
	PHARMACY CONSULTANT	XVIII B 39-2	600	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	150	
	PSYCHIATRIC	XVIII B __-2	192	
	RN CONSULTANT	XVIII B 38-2	0	
	PROGRAM CONSULTANT		14,174	
			0	41,988
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,064	
			0	2,064
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		840	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,152	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	1,992
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASTA CARE CENTER OF ELGIN **#0041608** **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		160	160
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	167,197	167,197
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	7,119	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	46,961	
			0	54,080
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	10,217	
	EMPLOYEE WANT ADS	XIX F	1,314	
	CONTRIBUTIONS	VI 20 XIX F	2,600	
	DUES & SUBSCRIPTIONS	XIX F	4,445	
	LICENSES & PERMITS	XIX F	1,327	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,656	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	667	22,226
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		5,529	
	EQUIPMENT REPAIR & MAINTENANCE		130	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	783	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		26,819	
	MESSENGER SERVICE		1,327	
	OUTSIDE BOOKKEEPING SERVICES		(2,428)	32,160

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	134,123	
	UNEMPLOYMENT COMPENSATION	XIX D	15,779	
	WORKERS COMPENSATION INSURANCI	XIX D	42,564	
	HOSPITALIZATION INSURANCE	XIX D	62,953	
	EMPLOYEE BENEFITS - OTHER	XIX D	7,689	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,436	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	264,544
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	3,263	
	TRAVEL	XIX G	0	
			0	
			0	3,263
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		780	780
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		105,617	105,617
27	**OTHER**			
	BAD DEBTS	VI 24	4,241	
			0	4,241

GRAND TOTAL COLUMN 3 OTHER 840,573

Facility Name & ID Number ASTA CARE CENTER OF ELGIN #0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			51,594	51,594		51,594	(18,317)	33,277			30
31	Amortization of Pre-Op. & Org.			641	641		641		641			31
32	Interest			34,762	34,762		34,762	(1,355)	33,407			32
33	Real Estate Taxes			73,316	73,316		73,316		73,316			33
34	Rent-Facility & Grounds			565,373	565,373		565,373		565,373			34
35	Rent-Equipment & Vehicles			18,781	18,781		18,781		18,781			35
36	Other (specify):*											36
37	**TOTAL Ownership**			744,467	744,467		744,467	(19,672)	724,795			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		63,767	92,225	155,992		155,992		155,992			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,845	55,845		55,845		55,845			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		63,767	148,070	211,837		211,837		211,837			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,855,624	366,931	1,733,110	3,955,665		3,955,665	(31,779)	3,923,886			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(18,317)	30		9
10	Interest and Other Investment Income	(1,355)	32		10
11	Discounts, Allowances, Rebates & Refunds	(211)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,177)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(783)	21		18
19	Entertainment		20		19
20	Contributions	(4,256)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(450)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,241)	27		24
25	Fund Raising, Advertising and Promotional	(10,217)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(2,438)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (43,445)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	11,666		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 11,666		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (31,779)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ASTA CARE CENTER OF ELGIN

ID# 0041608

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 3,091	6	1
2	BANK CHARGES	(5,529)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,438)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,388)	0	0	0	0	0	0	0	0	0	0	(1,388)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	3,091	0	0	0	0	0	0	0	0	0	0	3,091	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,703	0	0	0	0	0	0	0	0	0	0	1,703	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	2,165	0	0	0	0	0	0	0	0	0	2,165	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	2,165	0	0	0	0	0	0	0	0	0	2,165	16
	C. General Administration													
17	Administrative	0	(28,025)	0	0	0	0	0	0	0	0	0	(28,025)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(450)	1,114	0	0	0	0	0	0	0	0	0	664	19
20	Fees, Subscriptions & Promotions	(14,473)	1,170	0	0	0	0	0	0	0	0	0	(13,303)	20
21	Clerical & General Office Expenses	(6,312)	23,305	0	0	0	0	0	0	0	0	0	16,993	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	2,741	0	0	0	0	0	0	0	0	0	2,741	25
26	Insurance-Prop.Liab.Malpractice	0	1,074	0	0	0	0	0	0	0	0	0	1,074	26
27	Other (specify):*	(4,241)	8,122	0	0	0	0	0	0	0	0	0	3,881	27
28	**TOTAL General Administration**	(25,476)	9,501	0	0	0	0	0	0	0	0	0	(15,975)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(23,773)	11,666	0	0	0	0	0	0	0	0	0	(12,107)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(18,317)	0	0	0	0	0	0	0	0	0	0	(18,317)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,355)	0	0	0	0	0	0	0	0	0	0	(1,355)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(19,672)	0	0	0	0	0	0	0	0	0	0	(19,672)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(43,445)	11,666	0	0	0	0	0	0	0	0	0	(31,779)	45

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		LIST ATTACHED		ASTA HEALTHCARE	ELGIN	MANAGEMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$ 167,197	ASTA HEALTHCARE COMPANY INC		$	$ (167,197)	1
2	V	17	ADMINISTRATOR SALARY				75,590	75,590	2
3	V	10	NURSING SALARY				2,165	2,165	3
4	V	17	OFFICER SALARY				18,841	18,841	4
5	V	17	ADMINISTRATIVE SALARY				44,741	44,741	5
6	V	19	PROFESSIONAL FEES				1,114	1,114	6
7	V	20	SUBSCRIPTIONS				1,170	1,170	7
8	V	21	OFFICE EXPENSE				23,305	23,305	8
9	V	25	AUTO & TRAVEL				2,741	2,741	9
10	V	26	INSURANCE GEN & W.C				1,074	1,074	10
11	V	27	PAYROLL TAX & EMPL BEN				8,122	8,122	11
12	V								12
13	V								13
14	Total			$ 167,197			$ 178,863	$ * 11,666	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5	SEE ATTACHED										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ASTA HEALTHCARE COMPANY
Street Address: 134 NORTH MCLEAN BLVD
City / State / Zip Code: ELGIN, IL 60123
Phone Number: (847) 742 - 8822
Fax Number: (847) 742 - 9013

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATOR SALARY	DIRECT	1	1	$ 75,590	$ 75,590		$ 75,590	1
2	10	NURSING SALARY	PATIENT DAYS	182,843	6	11,953	11,953	33,124	2,165	2
3	17	OFFICER SALARY	PATIENT DAYS	182,843	6	104,000	104,000	33,124	18,841	3
4	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	182,843	6	246,966	246,966	33,124	44,741	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	182,843	6	6,150		33,124	1,114	5
6	20	SUBSCRIPTIONS	PATIENT DAYS	182,843	6	6,457		33,124	1,170	6
7	21	OFFICE EXPENSE	PATIENT DAYS	182,843	6	128,642	94,035	33,124	23,305	7
8	25	AUTO & TRAVEL	PATIENT DAYS	182,843	6	15,131		33,124	2,741	8
9	26	INSURANCE GEN & W.C	PATIENT DAYS	182,843	6	5,929		33,124	1,074	9
10	27	PAYROLL TAX & EMPL BEN	PATIENT DAYS	182,843	6	44,833		33,124	8,122	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 645,651	$ 532,544		$ 178,863	25

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5	ASTA MANAGEMENT	X		WORKING CAPITAL							8,000	5
	Working Capital											
6	BANK ONE		X	WORKING CAPITAL	INTEREST	REVOLV	375,000	480,000	REVOLV	PRIME+	21,510	6
7	A.I. CREDIT VORP		X	INT ON INSUR POLICIES							3,770	7
8	WELLS FARGO		X	ALARM SYSTEM	$614.00	1/20/02	36,870	22,737			1,482	8
9	TOTAL Facility Related				$614.00		$ 411,870	$ 502,737			$ 34,762	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 411,870	$ 502,737			$ 34,762	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	50,122	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	75,219	2
3. Under or (over) accrual (line 2 minus line 1).	$	25,097	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	48,219	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	73,316	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	56,561	8
1999	59,779	9
2000	61,231	10
2001	63,122	11
2002	68,219	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 $55219 APLLIES TO 2002 TAX BILL.

THE PAYMENT ON LINE 2 $20000 APPLIES TO 2003 TAX BILL

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF ELGIN COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0041608

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-15-176-011	NURSING HOME	$ 62,319.00	$ 62,319.00
2.	06-15-176-043	NURSING HOME	$ 791.80	$ 791.80
3.	06-15-176-044	NURSING HOME	$ 5,107.98	$ 5,107.98
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 68,218.78	$ 68,218.78

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FLOOR DRAIN			1997	1,297	33	39	33		216	9
10	INSTALL SHOWER VALVE AND DRAIN			1997	4,142	105	39	105		688	10
11	RE KEY DOOR LOCKS			1997	4,085	104	39	104		681	11
12	NEW AIR VENTS			1997	616	18	39	18		117	12
13	FIRE ALARM SYSTEM			1997	2,192	56	39	56		366	13
14	AWNINGS			1997	1,020	26	39	26		170	14
15	SEWAGE EJECTOR PUMP			1998	3,961	102	39	102		573	15
16	HOT WATER PUMP			1998	5,439	139	39	139		724	16
17	AWNINGS			1999	685	25	27.5	25		114	17
18	FLOORING			1999	2,474	90	27.5	90		409	18
19	ELECTRICAL WORK			1999	9,378	341	27.5	341		1,549	19
20	MAGNETIC DOOR LOCKS			1999	2,054	74	27.5	74		336	20
21	FIRE SPRINKLER SYSTEM			1999	3,868	141	27.5	141		640	21
22	BOILER			1999	4,890	178	27.5	178		808	22
23	NURSE STATION			2000	16,280	592	27.5	592		2,097	23
24	CONDENSING UNIT			2000	4,683	170	27.5	170		602	24
25	WATER HEATER			2000	8,731	317	27.5	317		1,123	25
26	POWER VENT FOR WATER HEATER			2000	2,682	98	27.5	98		347	26
27	NEW WALLS			2000	2,000	73	27.5	73		258	27
28	HOT WATER PIPING			2000	4,708	171	27.5	171		606	28
29	DRAPERIES			2000	2,303	264	7	264		1,641	29
30	EJECTOR PUMP			2001	14,041	511	27.5	511		1,299	30
31	ROOF			2001	6,218	226	27.5	226		574	31
32	COMPRESSOR			2001	3,501	127	27.5	127		323	32
33	PRESSURE BACK FLOW PREVENTER			2002	3,870	141	27.5	141		217	33
34	FIRE ALARM SYSTEM			2002	37,625	1,368	27.5	1,368		2,109	34
35	RE KEY LOCKS			2002	1,346	49	27.5	49		76	35
36	PATIENT SECURITY SYSTEM			2002	2,719	99	27.5	99		152	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	2002	$ 4,864	$ 177	27.5	$ 177	$	$ 273	37
38	NEW PIPE	2002	1,575	57	27.5	57		88	38
39	VINYL FLOORING	2002	17,779	3,982	5	3,556	(426)	7,112	39
40	HANDRAILS,BUMPERS,CORNER	2003	17,903	353	27.5	353		353	40
41	SMOKE DAMPERS	2003	1,904	37	27.5	37		37	41
42	DOOR ALARM SYSTEM	2003	3,097	61	27.5	61		61	42
43	SMOKING PORCH	2003	764	15	27.5	15		15	43
44	WALLCOVERINGS & PAINTING	2003	26,197	11,527	5	5,239	(6,288)	5,239	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 230,891	$ 21,847		$ 15,133	$ (6,714)	$ 31,993	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 160,800	$ 12,872	$ 16,080	$ 3,208	10	$ 88,809	71
72	Current Year Purchases	27,502	16,186	1,375	(14,811)	10	1,375	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 188,302	$ 29,058	$ 17,455	$ (11,603)		$ 90,184	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 419,193	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 50,905	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 32,588	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (18,317)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 122,177	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	FURN & EQUIP	$ 7,768	$ 689	$ 6,820	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 7,768	$ 689	$ 6,820	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ELGIN NURSING HOME PROPERTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		102		$ 565,373	30		3
4	Additions							4
5								5
6								6
7	TOTAL		102		$ 565,373 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 03/26/96
Ending 03/26/26

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 10,477 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT, HSK, ACT	1999 FORD BUS SUP-	$ 681.00	$ 8,304	17
18		REME			18
19					19
20					20
21	TOTAL		$ 681.00	$ 8,304	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	$		$ 15,810	$		$ 15,810	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			6,687			6,687	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			50,548			50,548	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				51,899		51,899	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-8					31,048		31,048	13
14	TOTAL			$		$ 73,045	$ 82,947		$ 155,992	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,809	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	799,901		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,678		6
7	Other Prepaid Expenses	2,093		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): RE ESCROW	19,183		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 844,664	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	184,612		15
16	Equipment, at Historical Cost	234,581		16
17	Accumulated Depreciation (book methods)	(213,222)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Dep-Fixed Asset**	18,618		22
23	Other(specify): COMPUTER SOFTWARE	14,738		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 239,327	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,083,991	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 167,799	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,063		28
29	Short-Term Notes Payable	612,244		29
30	Accrued Salaries Payable	39,759		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,949		31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,219		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTIES	145,022		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,020,055	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	561,408		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 561,408	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,581,463	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (497,472)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,083,991	$	48

*(See instructions.)

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (535,201)	1
2	Restatements (describe):		2
3	ROUNDING	10	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (535,191)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	37,719	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 37,719	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (497,472)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,891,222	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,891,222	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	93,565	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 93,565	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,752	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,752	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,355	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,355	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ADJ OF PRIOR YEAR EXPENSE	4,371	28
28a	DISCOUNTS EARNED	119	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,490	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,993,384	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	803,028	31
32	Health Care	1,403,388	32
33	General Administration	792,945	33
	B. Capital Expense		
34	Ownership	744,467	34
	C. Ancillary Expense		
35	Special Cost Centers	155,992	35
36	Provider Participation Fee	55,845	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,955,665	40
41	**Income before Income Taxes (line 30 minus line 40)****	37,719	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 37,719	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,086	2,309	$ 134,020	$ 58.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,078	10,237	294,016	28.72	3
4	Licensed Practical Nurses	3,612	3,765	79,590	21.14	4
5	Nurse Aides & Orderlies	44,534	45,258	501,004	11.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,875	4,369	125,480	28.72	8
9	Activity Director	1,961	2,113	28,477	13.48	9
10	Activity Assistants	4,805	5,258	42,455	8.07	10
11	Social Service Workers	1,684	1,761	30,725	17.45	11
12	Dietician					12
13	Food Service Supervisor	2,033	2,237	37,085	16.58	13
14	Head Cook	12,874	14,094	134,765	9.56	14
15	Cook Helpers/Assistants	4,036	4,129	26,547	6.43	15
16	Dishwashers					16
17	Maintenance Workers	2,113	2,310	36,263	15.70	17
18	Housekeepers	20,453	22,349	176,702	7.91	18
19	Laundry	6,585	7,116	52,646	7.40	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,779	3,017	60,857	20.17	23
24	Clerical	3,918	4,199	61,387	14.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,855	2,063	33,605	16.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	128,281	136,584	$ 1,855,624 *	$ 13.59	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 4,800	1-3	35
36	Medical Director	MONTHLY	9,250	9-3	36
37	Medical Records Consultant	MONTHLY	1,472	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	MONTHLY	600	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	MONTHLY	2,064	11-3	44
45	Social Service Consultant	MONTHLY	1,152	12-3	45
46	Other(specify) Program Consultant	MONTHLY	14,174		46
47	PSYCHO-SOCIAL	MONTHLY	3,324		47
48	PHYSICIANS		192		48
49	TOTAL (lines 35 - 48)		$ 37,028		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses	631	22,076	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	631	$ 22,076		53

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
	ADMIN		$ 0
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
ASTA HEALTH CARE MNGT - MANAGEMENT FEE	$ 167,197
TOTAL (agree to Schedule V, line 17, col. 3)	$ 167,197
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		54,080
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 54,080

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 42,564
Unemployment Compensation Insurance		15,779
FICA Taxes		134,123
Employee Health Insurance		62,953
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		7,689
EMPLOYEE PHYSICAL EXAMS		1,436
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,314
Health Care Worker Background Check	667
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	10,217
TRUST/FRANCHISE/CONTRIB/ETC	4,256
LICENSES & PERMITS	1,327
DUES & SUBSCRIPTIONS	4,445
MGMT CO ALLOCATION	1,170
TRUST/FRANCHISE/CONTRIB/ETC	(4,256)
Less: Public Relations Expense	(0)
Non-allowable advertising	(10,217)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,923

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	3,263
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,263

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATIN	1997	$ 4,534	3	$ 756	$	$	$	$	$	$	$	$
2	PAINTING/DECORATIN	1998	1,623	3	541	270							
3	PAINTING/DECORATIN	1999	1,843	3	614	614	308						
4	PAINTING/DECORATIN	2000	7,149	3	1,192	2,383	2,383	1,191					
5	PAINTING/DECORATIN	2001	3,139	3		524	1,046	1,046	523				
6	PAINTING/DECORATIN	2002	2,562	3			427	854	854	427			
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 20,850		$ 3,103	$ 3,791	$ 4,164	$ 3,091	$ 1,377	$ 427	$	$	$

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSOC $5498**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **16,659** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
of Public Aid during this cost report period. $ **55,845**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **#REF!** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees